**Date** April 17, 2019

**Location** Chrysalis Center - Hartford, CT **Time** 12:35 p.m. – 1: 45 p.m.

**Attendance**  See team summaries for roster of CHPC members and public participants.

**Welcome**

DAC members moved directly into their team meetings after lunch, at roughly 12:35 p.m.

**Team Meeting Accomplishments**

The DAC participants assembled directly into two teams [Needs Assessment Projects (NAP) and Quality Performance Measures (QPM)] and did not meet as a full DAC group. Each team:

* Completed tasks as described in the first page of the meeting summaries for each team (page 2 and page 8).

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* Identified next steps and tasks for completion prior to the May 2019 DAC meeting.

**Other Business**

No other business was introduced at the team meetings.

**Adjournment**

Team meetings adjourned at or before approximately 1: 45 p.m.

**Meeting Notes**

**Participants:** Clifford Batson, Susan Bouffard, Erick Carrion Rivera, Allison Champlin, David Colbert, Gina D’Angelo, Daniel Davidson, Martina De La Cruz, Harriet Dennis, Luis Diaz, Taylor Edelmann, Shawnee Estes, Lauren Gau, Deborah Gosselin, Daniel Hulton, Clunie Jean-Baptiste, Maria Lorenzo, Sarah Macone, Luis Magaña, Erin Malgioglio, Angel Medina, Mukhtar Mohamed, Consuelo Muñoz, Mitchell Namias, Peta-Gaye Nembhard, Hilary Norcia, Jackie Robertson, Rosie Rodriguez, Sue Speers, Roberta Stewart, Abigail Torres, Danielle Warren-Dias

**Facilitator:** Nilda Fernandez **DPH Liaison:** Susan Major **Recorder:** Mark Nickel

**Meeting Accomplishments**

The team accomplished the following tasks:

* **PrEP Data Presentation**. Luis Diaz shared information about the 2018 PrEP Navigation Pilot project. The team identified a potential indicator (i.e., PrEP to need ratio) for inclusion in the CHPC integrated HIV care and prevention plan. This discussion will continue at the QPM meeting in May.
* **STD Indicator**. The team discussed briefly the development of an STD indicator. Handout 2 with data from STI testing at the State Lab informed the discussion. The team explored how to establish a “developmental” indicator that focuses on the proportion of tests across specific testing assays and specimen types (e.g., rectal swab) with the intent to set a benchmark to increase the proportion of testing by specific specimen types, and how this relates to another important factor of increasing testing. The STI testing data at the State Lab could serve as a developmental baseline for this indicator. The team will continue to explore the feasibility of developing an indicator for specific specimen types (e.g., rectal swab) as well as benchmarks by population subgroups. This discussion will resume at the QPM meeting in May.
* **Quality Summit**. Peta-Gaye Nembhard shared an update on planning for the summit scheduled to occur September 18, 2019 in Hartford, CT. Clemens Steinbock from the Center for Quality Improvement and Innovation will now participate in planning sessions and will serve as the keynote speaker and moderator. Meeting Handout 3 contains specific information. The event planning committee will continue to meet (via phone).

**Identified Tasks**

1. Luis Diaz will make corrections to the PrEP slide deck and forward them to CHPC staff.
2. Ramon Rodriguez-Santana will develop materials to explain further the methodology to calculating the PrEP to need ratio, and to the extent possible provide preliminary calculations. He will prepare a presentation on the Syringe Exchange Program for delivery at the QPM meeting in May.
3. The Quality Summit workgroup will continue planning the summit with the subcommittee participating via conference call.
4. CHPC staff will email the corrected PrEP presentation to QPM team members.

**Welcome**

Nilda Fernandez, QPM chair, started the meeting at 12:33 p.m. and introduced Susan Major. Susan serves as the Department of Public Health (DPH) resource liaison to QPM and assists in managing QPM discussions. Nilda: a) reviewed the social contract developed by the QPM participants to create a productive meeting environment; b) requested that participants raise their hand to cue their intent to share a comment, to wait until called upon, and to say their name and comment when called upon; and c) reminded participants that the QPM uses a participatory and consensus building process; all voices and perspectives add value to the discussion.

**March Meeting Summary**

Nilda requested participants to review the meeting summary and to identify any additions, deletions, or corrections. Taylor pointed out that a typo appears to exist on page 3 (Ms. instead of Mr. Mohamed). Participants agreed by consensus to accept the meeting summary with no other additions, deletions, or corrections.

**2018 PrEP Navigation Pilot**

Luis Diaz from the DPH HIV Prevention Program shared information about the 2018 PrEP Navigation Pilot. Luis explained: a) the purpose of the pilot; b) the scope of implementation and participating agencies; c) the limitations to the data collection, analysis, and interpretation; c) preliminary findings for 182 clients; and d) program navigation outcomes and suggestions relevant to the development of a PrEP indicator. Luis presented similar information at the 4th annual PrEP summit.

The general conclusion of the presentation included:

* More than one-in-two (59%) PrEP clients were people of color (POC). 41% (75) PrEP clients were White, 34% (62) were Hispanic/Latinx and 20% (37) were Black / African American.
* Nearly eight-in-ten (79%) PrEP clients reported ‘Vaginal or Anal Sex without a Condom with a Male’ as an HIV risk; 6.5% reported ‘Vaginal or Anal Sex with HIV-Positive Male’ as an HIV risk.
* More than eight-in-ten (84%) PrEP clients were males.
* About three-in-ten (34%) PrEP clients were age 20 to 29 years old; 29.6% (48) were age 30 to 39 years old; 13% (21) were age 40 to 49 years old, and 13% (20) were age 50 to 59.
* Around eight-in-ten (76.4%) PrEP clients were MSMs and 8% (15) were heterosexuals.
* Overall, there was a 27.92% (265) increase in PrEP uptake from 2016 to 2017 in Connecticut.

Other points of emphasis by Luis during the presentation included:

* Changes such as new HIV test forms and the absence of consistent, national standards of care for PrEP navigation create a changing landscape that makes standardized data collection and evaluation processes difficult at this stage of the PrEP navigation rollout. The findings of PrEP navigation pilots will inform Connecticut’s approach to PrEP navigation – including a Connecticut PrEP Drug Assistance Program (PrEPDAP), as well as approaches that can be used in other states.
* PrEP resources for Connecticut can be found at several websites such as [www.positivepreventionct.org](http://www.positivepreventionct.org) and [www.pleaseprepme.org/connecticut](http://www.pleaseprepme.org/connecticut). Luis does his best to update national databases (e.g., CDC warehouse on PrEP access points) that feed these websites. These pages contain resources for patients, for providers, and for non-clinical providers in a variety of forms (e.g., videos, printable documents).
* Truvada costs approximately $1,600 per month for individuals with no insurance. Currently, Gilead offers $7,200/year in co-pay assistance for U.S. residents with no income limit. DPH is exploring ways to potentially cover the baseline labs required for the continuation of PrEP on a quarterly basis. The PrEPDAP (Drug Assistance Program) will potentially help increase access to the medication to those at increased risk for HIV and fall through the gaps (i.e., the working poor). Similar models continue to emerge across the nation (e.g., California and Washington). Connecticut continues to explore how to integrate any PrEPDAP resources with the Connecticut Drug Assistance Program.
* In 2019 - 2022, PrEP navigation will expand to include eight (8) agencies that offer OTL (Outreach, Testing and Linkage) and nine (9) that deliver routine testing.

Team members discussed the following points relevant to the PrEP presentation:

* Danielle confirmed that concern exists in the field about accessing PrEP due to costs such as paying for labs, especially for populations such as college students who may maintain insurance coverage (possibly through parents) and do not have money to pay high co-pays. At the moment, the 340B Pharmacy program funds for PrEP no longer pays for labs.
* Luis noted some limitations that exist with the 340B program. Luis suggested reaching out to Gilead’s co-pay program and indicated that the Office of Pharmacy Affairs (OPA) will be operational again in January 2020.
* David suggested that the program should operate similar to CADAP in which federal funding gets used as the payer of last resort. This means populations such as uninsured or underinsured students should have some access point to get started in the process which includes accessing any drug company discounts. Gina confirmed that policies and procedures are and will continue to be developed and incorporate best practices from other states as well as what works for Connecticut.
* Luis stated that the goal date to rollout PrEP DAP is August 1, 2019. Gina stated increasing access to PrEP remains a priority for the Governor. Ramon added that the program will continue to represent a pilot project until such time sustainable funding has been identified – including the incorporation of features into PrEP DAP that work well in the CADAP program.
* Jackie described some practical concerns using examples in Waterbury of disconnects to service at testing access points and connection to lab service. All of the necessary resources exist in the community. However, some services operate on very limited hours (e.g., two days per week for three hours) and this creates a challenge for maintaining continuity of service for clients. Luis explained briefly how these differences occur. For example, some federally qualified health centers (FQHCs) operate in-house labs at no cost provided that the individual is a patient at the FQHC. Gina stated that coordination within communities should remain a priority, and that policies and procedures for PrEP DAP will reinforce the need for coordination.
* Taylor observed that the pilot program occurred in New Haven and Hartford, and suggested including communities such as Danbury that contain large numbers of undocumented individuals. Luis agreed and stated that 2018 represented the initial pilot year and future years will include scaling to additional communities and priority populations.

Nilda thanked Luis for sharing the information and answering questions. Luis stated that he would make corrections to the slide presentation and send the updated copy to the CHPC staff for distribution to QPM team members.

**PrEP Indicator Development**

Nilda reminded the team of the previous discussions to add a PrEP indicator to the CHPC indicators. Nilda asked team members to voice their current level of interest in developing a PrEP indicator.

* The team agreed by consensus to develop a PrEP indicator and recommend this as an addition to the statewide HIV integrated care and prevention plan.

Nilda stated that the presentation by Luis included program outcomes and measures as well as possible indicators: a) the number of people who initiate PrEP; and b) the number of people in PrEP at 3, 6, 9 and 12 months. Nilda opened the floor for discussion on PrEP indicators.

* Daniel observed that the 2019 PrEP navigation outcomes used by DPH represent program outcomes that are important for quality assurance and quality improvement. These outcomes, however, should not be used as the statewide indicator. Ramon suggested using a PrEP to need ratio.
* Ramon explained that the “***PrEP to need ratio***” is the number of people on PrEP divided by the number of new HIV diagnoses within that given year. This ratio can be calculated for subpopulations (e.g., gender, race/ethnicity, age groups) provided that collection of these data sets occurs or can be accessed from the PrEP prescriptions.
* Ramon stated that research studies and poster presentations on distribution of active PrEP prescriptions and the PrEP to need ratio continue to grow across the nation. These studies provide context and help inform Connecticut’s approach. Ramon stated that national studies often use measures that may not make much sense in Connecticut. For example, in one national study results were framed as “new diagnoses per 100,000 population” and showed a nationwide PrEP to need ratio of 1.5 prescriptions to new HIV diagnoses with regional variations ranging from 0.9 to 2.9. This metric will not work in Connecticut simply because Connecticut does not have 100,000 PLWH.
* Ramon stated that some limitations would exist in developing a PrEP to need ratio. This would include a one year “lag” in data. Ramon stated that the PrEP to need ratio could be calculated within Connecticut overall and by subpopulation. The initial year(s) should be considered “developmental” until a PrEP DAP program exists and an agreed upon methodology exists.
* Danielle encouraged the group to be forward thinking and consider options that allow PrEP data sets to connect with other indicators (e.g., housing, STDs). This may mean changing data collection forms and data sharing processes.

Nilda asked the team members to agree by consensus to pursue the development of a PrEP to need ratio as the PrEP indicator.

* QPM team members agreed by consensus to use the PrEP to need ratio.

Ramon offered to serve as the subject matter expert and to explain the PrEP to need ratio in more detail (e.g., show calculations, show example data sets from national studies) at the May QPM meeting.

Nilda thanked team members for a productive discussion.

**STD Indicator**

Nilda stated that the QPM team had not yet completed discussion on the development of an STD Indicator. Thus far, the team had: a) agreed in January that the STD indicator should focus on youth ages 13 through 24; and b) received in March a STD presentation by Mukhtar Mohamed.

Nilda referred QPM team members to Handout 2 that showed STI testing data from the State Lab during the time period May 16, 2018 to March 18, 2019. The data showed specimen type (e.g., urine, vaginal swab, rectal swab) and the number and percent of positive tests for chlamydia and gonorrhea.

Nilda opened the floor for discussion about possible STD indicators, and the extent to which the team remained interested in developing an STD indicator

* Danielle stated that the development of an indicator remains an urgent priority as infections continue to increase. Danielle believed that STI tests should be automatic, and providers must perform more rectal swab testing. A point of emphasis for the indicator might be number and/or percentage of rectal swabs.
* The QPM team agreed by consensus that an STD indicator should be developed. However, the indicator must be connected to data sets that are accessible or uniform across providers and/or the state.
* Nilda confirmed that the PrEP indicator and the STD indicator should create a framework to understand progress across Hep C, STDs, PrEP, and HIV. Susan encouraged the group to narrow in on an initial STD indicator that could represent a starting point or a “developmental” indicator.
* Ramon stated that the STI testing data from the State Lab represents a baseline or a starting point and expressed concern that it represents 10% of all tests. Ramon stated that testing data could be expressed in terms of rates per subpopulations (e.g., age groups, race/ethnicity).
* Daniel suggested focusing on shifting the proportion of testing by specimen type. For example, in three years, an indicator could show an X% increase in the proportion of rectal swab specimen types as a proportion of all tests.
* Gina and Susan observed that the approaches under consideration represent different pathways, and the team must clarify what it wants to know:
  + Do you want to focus on increasing STD testing in general? If you focus on increasing STD tests in general, that will result in more rectal swabs – simply because more people are getting tested as the same proportions. Is that sufficient?
  + Do you want to focus on shifting the proportion of test types in the context of STD testing data?
  + Do you want to focus specifically on an indicator for rectal swabs and a specific population?
  + What are the limitations associated with each approach? For example, does the data exist? Do the providers have the resources to create change?
* Roberta stated that focusing on appropriate testing for MSMs (e.g., rectal swabs) remains important, especially for providers serving this population. However, we first need to focus on increasing access to testing in general. In the meantime, we can also encourage specific providers can conduct PDSAs to increase rectal swab testing – which would shift the proportion of type of test.
* Daniel added that testing is prevention. Increasing the number of tests (even at the current proportion of specimen types) will result in more people receiving care and treatment.
* Jackie provided content from the field though a description of how urine tests must be accompanied by additional questions (e.g., type of sex) to understand the relevance of and need for more specific tests (e.g., rectal swab). Jackie pointed out that barriers exist because of limited lab hours (at the health department).
* Taylor agreed that increasing STI tests and shifting the proportion of type of test represents a good starting point provided that an emphasis be placed on increasing oral or rectal swabs, and quoted AC (physician) who says, “if you are not doing oral or rectal swabs, you will be missing 90%.” Taylor stated that this indicator would support the Getting To Zero campaign.
* Danielle encouraged the group to focus on any method to increase testing in general and oral and rectal swabs in specific. She referenced the trajectory of gonorrhea in the 1970s in which things got much worse before getting better.
* Roberta stated that we must also consider the extent to which provider sites have access to resources. Developing a statewide indicator that may not align with how the delivery system current works or is resourced will result in an indicator that does not change. Jackie agreed with this perspective and shared information about limitations facing health department services.
* Ramon stated that the STI testing data represents a baseline only. Any indicator and benchmarks established by QPM should be considered “developmental” or subject to review and change.

Nilda closed out the STD indictor discussion by acknowledging progress. Specifically, the team will continue the discussion at the May QPM meeting about a “developmental” STD indicator that relates to increasing testing and/or shifting the proportion of tests.

**Quality Summit Update**

Peta-Gaye Nembhard shared an update on planning for the summit scheduled to occur September 18, 2019 in Hartford, CT. Clemens Steinbock from the Center for Quality Improvement and Innovation will now participate in planning sessions and will serve as the keynote speaker and moderator. Peta-Gaye referred participants to meeting Handout 3 for additional information.

* Danielle suggested that the committee engage a FQHC from Southwestern Connecticut like Optimus as a presenter or contributor to the best practice carousel. Taylor will follow up internally with leaders/supervisors at Optimus.
* Gina encouraged the planning team to engage Part C providers who receive funding directly from the federal government and often represent community health centers.
* Nilda stated that Melanie (ACT) was following up with CRT about homelessness services.
* Gina stated that Positive Prevention (Dante) may be helpful with identifying local projects using technology in prevention and care.
* Peta-Gaye reminded everyone that any PDSA project – including those that may not have produced positive results during the first iteration will contribute to the event. Identify any efforts across the state where partners seek improvement. All projects and findings contribute positively to this learning community. Peta-Gaye stated that Dave will follow up with Xavier about projects from the Southeast.
* Pete-Gaye and Lauren stated that the next call will focus on the best practice carousel segment of the agenda. Melanie, who has organized this type of event, will serve as a subject matter expert, and has assured the group that a teleconference will suffice.

The event planning committee will continue to meet (via phone).

**Meeting Feedback**

Nilda asked the group to share general feedback and to place any specific feedback on the CHPC meeting feedback forms. Team members felt the presentation was informative and the discussion was productive. Several team members requested that future handouts are not copied on pink paper.

**Adjourn**

Nilda thanked everyone for their participation and adjourned at 1:45 pm.

**##End QPM Notes##**

**MEETING SUMMARY**

**Date:** April 17, 2019 **Location:** Chrysalis Center (Hartford, CT)

**Start Time:**  12:40 p.m. **End Time:** 1:45 p.m.

**Participants:** Page 2 shows attendance

**Chair:** Barry Walters **Recorders:** Emily Jablonski

**Meeting Accomplishments**

* Participants approved by consensus the March 2019 meeting summary.
* CHPC members were encouraged to apply for the open leadership position of NAP Team leader.
* Participants reviewed an updated version of the NAP Team’s 2019 work plan.
* Participants discussed the second iteration of Connecticut’s statewide workforce survey by reviewing an existing tool from the Black AIDS Institute, and agreed to use it as a foundation.
* Participants discussed approaches to including questions related to cultural humility on the workforce survey.

**Welcome & Introductions**

Mr. Barry Walters (NAP Team chair) welcomed participants to the meeting and asked everyone to introduce themselves by name and organizational affiliation or town. Mr. Walters emphasized the important of creating an environment of acceptance and respect, and organizing the discussion to produce results. Mr. Walters described the NAP Team: a) completes special projects such as needs assessments, focus groups, or briefing papers that help the CHPC develop its plan and achieve its goals; and b) uses a consensus model of decision-making (not voting) to include all voices and perspectives – including public participants in the process.

**Review of March 2019 Meeting Summary**

Participants reviewed the March 2019 summary and approved it by consensus with no additions or corrections.

Individuals who regularly participate in the CHPC NAP Team clarified to newer participants that the NAP Team summaries capture themes, high-level decisions, and next steps. They do not typically reference participants by name (i.e., use a more detailed “minutes” approach).

**Needs Assessment Focus Group Design: Update**

Mr. Walters reviewed progress to date on the focus group development from the prior meeting as well as additional design input provided by the CHPC co-chairs and HIV Funders Group. He thanked the group for their work on the questions, noting that the NAP Team has been leading needs assessment activities for over a year. Mr. Walters added that the CHPC Membership Awareness Committee (MAC) would review the draft questions and provide another round of feedback. By the end of the April CHPC meeting, feedback would be shared with CHPC co-chairs. Co-chairs would approve the questions, at which time staff would begin to schedule the focus groups for summer 2019.

**HIV Workforce Survey**

NAP Team participants reviewed a comprehensive set of questions originally used to survey a handful of states’ HIV workforces. The questions were grouped by the following topics:

* HIV Knowledge
* Basic Knowledge & Terminology Questions
* Treatment Questions
* Clinical or Biomedical Interventions
* Familiarity with Biomedical Interventions
* Efficacy of Biomedical Interventions
* Stigma
* Questions for Healthcare Workers

NAP Team participants noted some concerns or challenges related to the questions:

1. The volume of questions might discourage participants from taking or finishing the survey.
2. Some of the questions were “too specific” (i.e., too tailored to certain roles) and thus may not be appropriate on a survey that will be disseminated to all members of the HIV workforce.
3. The stigma questions were weak and did not align with the needs assessment survey questions on stigma.
4. The set of questions did not address cultural humility.

The NAP Team participants agreed to address the fore mentioned concerns by: revising the original set of questions, researching other similar tools, reducing the number of questions, brainstorming stigma questions, and continuing a discussion about cultural humility. Participants also agreed that, while highly important, cultural humility might not “belong” on a survey tool related to workforce skills and abilities (and might be better as a standalone assessment).

**Next Steps**

* CHPC staff will explore alternate workforce survey tools, including tools that have questions around stigma and cultural humility. NAP Team members will provide additional input as available / necessary.
* NAP Team members will review the meeting notes and provide additional input at the May meeting (or by e-mail prior to the meeting).
* CHPC staff will continue to finalize needs assessment focus group logistics (e.g., location, dates) with CHPC leaders and the Membership and Awareness Committee.

**Other Business**

Participants did not introduce any new or other business. Mr. Walters encouraged interested CHPC members to apply for the open leadership position as NAP Team chair.

**Feedback**

Mr. Walters thanked everyone for providing input and helping to shape the next iteration of workforce survey questions. He asked participants to place any additional meeting feedback on the CHPC general meeting feedback form.

**Adjournment**

Mr. Walters adjourned the meeting at 1:45 p.m.

**Meeting Attendance**

Laura Aponte; Samuel Bowens; Tom Butcher; Reina Cordero; Angelique Croasdale-Mills; Dante Gennaro; Cynthia Hall; Shanay Hall; Venesha Heron; Andrea Lombard; Cecil Tengatenga; Barry Walters